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A Guide To Providing Substance Abuse Services To Those With Developmental Disabilities

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Project ADAPT: A Differential Approach to Prevention and Treatment of Substance Abuse Among Persons with Developmental Disabilities

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PURPOSE FOR DEVELOPING SUBSTANCE ABUSE SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

A review of the literature indicates that an estimated ten percent of the general population have problems with alcohol abuse and/or dependency. Alcohol or substance abuse occurs when the use of alcohol or other drugs causes any kind of problem in a person's life and he or she continues to use them (The Maine Approach, 1984).

Recent studies are consistent in finding that alcohol problems are no less for those with developmental disabilities than for the general population (DiNitto & Krishef, 1983; Krishef, 1986; Westermeyer et al., 1988). This is especially true as the deinstitutionalization movement has provided full participation in the activities of the larger community. Along with this participation in the community has come the access to a number of previously inaccessible activities, including the consumption of alcohol.

It is becoming evident that, as a result of accessibility to alcohol, persons with developmental disabilities do drink and suffer from alcohol-related problems (Rehab Brief, 1982). Having been removed from a structured environment and placed in the mainstream of the community, these individuals are now experiencing the stress of having to make their own personal choices and decisions. They are also finding that this stress (as well as conflicts and fears) can be disguised or relieved through drinking (Selan, 1979). Managing stress, resolving conflicts, dealing with fears, and developing social and decision-making skills are all, however, areas that can be

developed through the use of education, thus reducing the chance that the individual will turn to alcohol or other drugs to solve life's problems.

The scant statistical information available regarding the incidence of substance abuse among those with developmental disabilities must not become a rationale for failing to serve those in need. The Rehabilitation Act of 1973, Section 504, states, "No otherwise qualified handicapped individual in the United States, as defined in section 7(6), shall, solely by reason of his[/her] handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (PL 93-112, 93rd Congress, H.R. 8070, 9/26/73). The intent is for all community services to find ways to provide for its disabled members services that are equal in quality to those afforded others in society.

NEEDS ASSESSMENT

Staff from Project ADAPT (A Differential Approach to Prevention and Treatment Among Persons with Developmental Disabilities) conducted a review of the current literature and surveyed the state of Montana regarding the incidence of alcohol-related problems among persons with developmental disabilities, especially those who are in independent or transitional living situations. In March 1988, ADAPT staff contacted all twelve Training and Contract Managers (TCMs) within Montana's Developmental Disabilities Division (DDD), as well as seven

program managers, three social work supervisors and five case managers.

Over ninety percent of the individuals contacted felt that there was a problem of such severity that it needed to be addressed. The reported incidence of alcohol-related problems among independent and transitional living persons with developmental disabilities ranged from ten to thirty percent. In addition, there were reports of individuals living in group home situations who were also suffering from alcohol-related problems. A number of respondents stated that the traditional methods of dealing with such problems had not proven successful and that they would be receptive to any assistance which might help alleviate such problems.

The results of these initial steps pointed out that: 1) With the increased experience of independence and community integration, a greater number of persons with developmental disabilities are at risk for developing alcohol abuse and alcohol-related problems; 2) new and adapted methods and materials are needed to successfully address these problems among this particular population; and 3) there currently is no program in place to successfully accomplish this. These results formed the basis for Project ADAPT. The Montana Developmental Disabilities Planning and Advisory Council (DDPAC) funded Project ADAPT in cooperation with the Institute for Human Resources/Montana University Affiliated Program Satellite (IHR/MUAPS). The purposes of this demonstration project were: 1) to design and implement a model approach to developing substance

abuse services for persons with developmental disabilities, and 2) to disseminate guidelines so that other interested professionals may replicate the model in their own communities.

HOW TO USE THIS GUIDE

The following set of guidelines is based on the experiences in Project ADAPT. The ADAPT model was based largely on A Guide for Professionals, developed by Carol Lindbo, and The Maine Approach: A Treatment Model for the Intellectually Limited Substance Abuser (1984). Use of these two resources, in conjunction with this guide, will greatly enhance the reader's ability to replicate the ADAPT model. This guide directs the reader to the current literature and materials found to be helpful in developing and providing substance abuse services for persons with developmental disabilities. It provides specific examples which are meant to illuminate topics and encourage the reader to be creative. The guide is not meant to be a step-by-step "cookbook" approach but rather a stimulus to help readers design a program for their particular circumstances.

"Removing Barriers" is addressed to professionals working either with persons who have developmental disabilities or with persons who abuse substances. It is also written for policy-makers and agency directors who recognize the changing needs of persons with developmental disabilities and want to enhance the system's ability to respond to those needs.

The ADAPT model ascribes to an approach which recognizes the need for modification in policy as well as change in direct

service approaches. Furthermore, it emphasizes the need for those coordinating and providing services to expand their knowledge and skills in order to impact the delivery of substance abuse services to persons with developmental disabilities. It is not the purpose of this guide to teach substance abuse professionals to become experts about developmental disabilities, nor is its purpose to teach disability professionals to become chemical dependency counselors. Rather, these guidelines encourage the cooperation of state and community service providers, as well as provide information for working directly with persons who have developmental disabilities and are in need of substance abuse services.

SETTING THE STAGE

A few important assumptions should be clarified before going any further:

1. The model described is designed to be integrated into existing resources and services rather than to create a new and separate service. The ADAPT model assumes, then, that the system responsible for providing the services exists. Professionals are encouraged to rely on one another's expertise and learn what is needed to enhance the service delivery system's ability to respond to substance abusing individuals who have developmental disabilities.

2. This document addresses two areas in which to intervene when developing substance abuse services for persons with

developmental disabilities. First, it provides a community approach that addresses the issues, identifies potential barriers, and provides possible solutions for modifications in the system. Second, it provides prevention/education and treatment guidelines for professionals interested in directly serving persons with developmental disabilities in need of substance abuse services.

3. Every community and each individual is different. Just as many of the procedures and materials in Project ADAPT were adapted to meet the needs of persons with developmental disabilities in a specific community, professionals are encouraged to adapt these guidelines to meet the needs of the communities and individuals they serve.

4. The ADAPT model assumes a commitment of time and energy. Based on the objectives completed in the demonstration project, it can be expected that full implementation will take up to twelve months. Ideally, one professional from each field (substance abuse and disability services) will be designated as local project coordinator, and those individuals as a team will provide leadership in developing services. Ideally, this team will also have the support of their employers, i.e., the time will be provided (each project coordinator will be given up to 10 hours/week), a budget for materials will be included, and back-up to develop the inter-agency and state cooperation required will

be there. In reality, all these components will not always exist; the more they are developed, however, the more able will the program be to meet the needs of the community.

5. Teamwork is essential. In order to ensure that persons with developmental disabilities are guaranteed the availability of a full range of services--from prevention/education to treatment and aftercare--cooperation must begin from the start, and start at the top. When proceeding, the support and cooperation of policy-makers and all relevant community resources should be encouraged.

PART I: COMMUNITY APPROACHES TO DEVELOPING SUBSTANCE ABUSE SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

The tasks of working with the community to develop substance abuse services for persons with developmental disabilities are varied. The major responsibilities are defined below. The list is then followed by a more detailed description of each task.

A. Identify Resources. Identify community resources; create and strengthen understanding and communication between them. Gather and maintain community support and momentum.

B. Determine Community Needs. With agency input, assist in identifying their needs, limitations and responsibilities.

C. Identify Barriers. Identify and research local as well as state-wide issues. Remove or minimize existing barriers that could bog down or undermine the success of the project.

D. Develop Service Agreements. Encourage and facilitate the development of service agreements and contracts between agencies.

E. Coordinate and Provide "Cross-Training". Review and develop training materials for professionals. Train and enlist others in the disabilities and substance abuse professions to assist in ongoing outreach and training.

A. Identify Resources

Policy changes that will assure the provision of substance abuse services for persons with developmental disabilities will depend on the cooperation of a number of state agencies. In Montana, those primarily responsible include the Chemical Dependency Bureau within the Department of Institutions, the Developmental Disabilities Division (DDD) within Social Rehabilitation Services (SRS), and the Department of Family Services (DFS) within SRS. Agency directors and other community professionals who maintain ongoing contact with state personnel should be consulted to establish appropriate communication channels.

At the local level, service providers and community resources can become valuable allies. Get to know resources early on. Look for people or programs with experience or interest in both chemical dependency and developmental disabilities. For example, detox units and police officers are repeatedly confronted with persons with developmental disabilities in alcohol-related crises. With education, they can become valuable referral sources. Local YMCAs and other recreation facilities should be approached to provide support services that can help persons with developmental disabilities participate in the community. Furthermore, programs and individuals that directly serve persons with developmental disabilities or substance abuse problems should be assisted in becoming an effective part of the referral, education and treatment process.

Resources to target for education, coordination and awareness-building include:

1. Special Education Programs
2. Substance Abuse Services
3. Probation/Parole
4. Volunteer Services/AA
5. Supported Employment
6. Medical Services
7. DFS Services
8. Courts/Police
9. DD Services
10. Hospital Detox
11. Voc Rehab
12. Local YMCAs

B. Determine Community Needs

It is important to recognize that state agencies are the "gatekeepers" for change in statewide policies. To justify institutional change, these policy-makers need documentation of the scope of the problems and the potential need for services (de Miranda & Cherry, 1989). This information can be gathered by surveying local service providers and can be validated by documentation from research and current literature (see Bibliography).

The results of a survey (whether formal or informal) help demonstrate the need for services as well as determine the kinds of training and policy changes community services will want to consider in order to better serve persons with developmental disabilities who have substance abuse problems. A survey can also help assess community professionals' perceptions of substance abuse problems of persons with developmental disabilities and can provide information on professionals' attitudes, opinions, and awareness.

Policy-makers and service providers may also need education about the implications of the Rehabilitation Act of 1973. Even though this act has been in place for sixteen years, its effects on substance abuse services are only now becoming apparent. Likewise, disability professionals are just beginning to grapple with the problem of substance abuse among their consumers.

The following questions can assist in determining the community's needs. A number of these questions were taken from the "Bay Area Project," directed by Linda Cherry (de Miranda & Cherry, 1989). One of the objectives of that project was to survey agencies which provide alcohol and drug services or disability services about their experience with and understanding of clients who have certain disabilities as well as problems with alcohol or other drugs. Those interested in the survey can find the address in the list of resources at the end of this guide.

Questions to Disability Workers

- What is the incidence of alcohol/drug problems among those persons you serve who have developmental disabilities?
- What training have you received in working with a person who has a developmental disability and a substance abuse problem?
- What is your most frequent response to a client who has a substance abuse problem?
- What percent of your caseload is required to take medication in order to manage his/her disability?

- What information do you systematically use to screen for drug/alcohol problems during your intake process?
- Do you provide outreach services to substance abuse professionals to help them work with persons with developmental disabilities?
- What linkages currently exist between your services and substance abuse services?

Questions to Substance Abuse Professionals

- What training have you received in working with a person who has a developmental disability and a substance abuse problem?
- How many persons with developmental disabilities have you served in the last reporting year?
- What materials do you have available to serve persons with developmental disabilities?
- Do you provide outreach to disability professionals to help them work with clients with substance abuse problems?
- What linkages currently exist between your services and disability services?

C. Identify Barriers

It is extremely helpful to identify sources of resistance and inherent problems within the system as early as possible since many of these "barriers" can be removed through education and awareness. Others can be minimized through sensitivity and establishing service agreements.

A list of possible barriers was compiled from experiences in Project ADAPT as well as from conversations with three other sources working to develop substance abuse services for persons with developmental disabilities around the country. (Carol Lindbo of Alcohol Outreach in Fargo, ND; John de Miranda, director of the California Alcohol, Drug, and Disability Study in San Francisco, CA; and Julie Erwin of Project A.I.D. at Kent State University in Kent, OH). It is hoped that this list will help those developing services to respond quickly to potential problem areas.

Barriers Encountered in the Substance Abuse Profession

1. Lack of interest by the counselors to serve those with developmental disabilities.
2. Lack of training and knowledge to treat persons with developmental disabilities.
3. Lack of available materials.
4. Perceived lack of need to focus on this population.
5. Perception that persons with developmental disabilities do not follow through with attendance.
6. The perception that persons with developmental disabilities are too low-functioning to participate effectively.
7. The belief that persons with developmental disabilities are not motivated to receive treatment.
8. Concern that more work would be required by staff.

9. Conflicts between "drug free" treatment philosophies and clients who take prescribed medications to manage disabilities (i.e., pills to manage "mood swings").
10. Problems integrating persons with developmental disabilities into the group process.
11. Cost of developing resources for persons with developmental disabilities and implications that "once we start serving mentally retarded persons, next it's head injuries and learning disabilities, etc." which would overwhelm limited resources.
12. Payment issues.

In regards to payment issues, the out-patient chemical dependency programs in Montana (and many private chemical dependency counselors) are not Medicaid eligible and, therefore, are unable to accept the most common third-party payer available to persons with developmental disabilities. Additionally, private in-patient programs often provide only medical detox since it is the only alcohol-related service covered by Medicaid. Furthermore, when individuals receive such services as Vocational Rehabilitation, V.R. counselors may be reluctant to use their limited financial resources to pay for chemical dependency counseling services, particularly when out-patient services are billed at the top hourly rate, rather than being billed at the client's level of ability to pay (which may differ by as much as $50 per hour).

Barriers Encountered with Disability Workers

Barriers were also encountered within the DD profession. For example, Department of Family Services (DFS) case managers, who were designated as the central referral source in Project ADAPT, expressed feelings of being overwhelmed and not having time to respond to additional requests. They cited that morale was low and that responsibilities had doubled due to new state Individual Habilitation Planning (IHP) requirements. Barriers among disability workers may include:

1. Viewing alcohol and drug misuse/abuse as a minor issue for people with developmental disabilities.
2. Reluctance to address such problems with clients.
3. Inability to recognize possible substance abuse problems and high-risk individuals.
4. Lack of knowledge about substance abuse and the disease concept of chemical dependency.
5. Lack of skills to intervene with individuals who have substance abuse problems.
6. Fear that dealing with alcohol and drug problems among clients could put an added burden on an already over-burdened system.
7. A belief that intervening with a client's substance abuse interferes with their rights.
8. The frustration that approval for in-patient treatment can take up to 6 months.
9. Disability professionals themselves inappropriately using alcohol and other drugs and thus not seeing such use as problematic for their clients.

D. Develop Service Agreements

In developing service agreements, it is important to know the limitations and responsibilities of each involved party. Several sources can provide guidance. They include: 1) the Rehabilitation Act of 1973, 2) Montana State Regulations, 3) contracts between the State departmental agencies and local providers, and 4) local providers' policy and procedure manuals. Listed below are areas recommended by The Maine Approach (1984) in which to consider development of service agreements.

The following are suggested responsibilities of developmental disability agencies that should be identified in service agreements.

For Developmental Disabilities Agencies

1. Screening clients for potential referral for substance abuse problems.
2. Implementation of specific screening tools and procedures by which to identify substance abuse problems.
3. Referral procedures.
4. Rate of payment for substance abuse services, i.e., individual, group, education, therapy, assessment.
5. Method and source of payment for substance abuse services.
6. Transportation to and from services.
7. Provision of relevant reports and information to substance abuse services.
8. Confidentiality.

9. Provision of staff training to substance abuse and developmental disabilities service providers.
10. Provision of consultation to substance abuse providers regarding specialized treatment methods.
11. Inclusion of substance abuse service providers in habilitation planning meetings for common clients.
12. Involvement and cooperation with substance abuse service providers regarding recovery needs.

The following are suggested responsibilities of substance abuse agencies that should be identified in service agreements.

<u>For Substance Abuse Service Providers</u>

1. Provision of contracted substance abuse services, i.e., assessment, group, individual sessions.
2. Development of treatment plans for the delivery of appropriate services.
3. Involvement of developmental disabilities service providers in treatment planning and delivery.
4. Provision of reports and information to developmental disabilities service providers.
5. Provision of staff training to disabilities and substance abuse service providers.
6. Provision of consultation services to disabilities professionals.
7. Confidentiality.

E. Coordinate and Provide "Cross-Training"

Cross-training between disability and substance abuse professionals, as well as educating others--such as doctors, police, and parents of potential clients--will help develop needed support and coordination.

Listed below are possible training objectives with which to start. The Maine Approach (1984) provides a more comprehensive list of possible training areas.

Training Objectives for Developmental Disabilities Service Providers

A. Identification and Referral of Substance Abuse
   1. Understand the psychology and physiology of substance abuse
   2. Develop some basic diagnostic criteria for identifying substance abuse
   3. Become familiar with the different types of treatment and referral sources

B. Intervention
   1. Assess the psychological motivators
   2. Know the elements of an intervention process
   3. Develop a plan for confronting the substance abuser
   4. Practice intervention

C. Treatment and Recovery: Role of Support Service Providers
   1. Know the primary methods of substance abuse treatment

2. Assess your own attitudes about substance abuse
3. Understand the importance of concerned person involvement in treatment and the recovery process
4. Recognize the limitations of substance abuse treatment
5. Recognize professional "enabling" behaviors

Training Objectives for Substance Abuse Treatment Providers

A. Overview of Developmental Disabilities
   1. Be familiar with the different types of services for persons with developmental disabilities
   2. Distinguish between myths and facts of mental retardation
   3. Understand the rights of persons with developmental disabilities

B. Strategies for Working with Developmental Disabilities
   1. Understand the process of learning
   2. Be familiar with historical approaches to treatment
   3. Understand methods of goal selection
   4. Understand methods of teaching persons with developmental disabilities
   5. Understand the Individual Habilitation Planning process

To summarize, persons with developmental disabilities do not fit into existing treatment programs. To be effective, services need to adopt special approaches to deal with the individual who has a developmental disability and abuses substances:

1. Service providers must be able to identify substance abuse problems and make timely referrals.
2. Service providers need to be aware of the rights of persons with developmental disabilities.
3. Service providers must be active in the treatment planning process and aftercare of clients.

PART II: WORKING DIRECTLY WITH PERSONS WHO HAVE DEVELOPMENTAL DISABILITIES AND ARE IN NEED OF SUBSTANCE ABUSE SERVICES

Part II asserts that persons with developmental disabilities need the same kinds of services as others. It is the delivery that needs to be different:

* need more intense support
* need more structure
* need more concrete approaches
* need to reach the client at their level of understanding

"Unless a professional achieves personal comfort out of working with an irreversible defect and is content with small gains over an extended period of time, [s]he can be most effective by not working in the field of mental retardation!" (Selan, 1976). This statement is not intended as an "out" to those who may feel an initial reluctance to work with individuals who have developmental disabilities. Rather, since we are responsible for providing services to all who are in need, this statement suggests that many of us may have some personal attitudes and issues to address before we walk into that room with the individual who has a developmental disability and a substance abuse problem. For example, those who work in the substance abuse profession may feel disappointed by the comparatively slow progress made by the individual with a developmental disability. Similarly, the developmental

disability professional may be quick to "write off" the substance abusing client because they are "hopeless" or perhaps because there are many more individuals who need the services and will readily comply.

Although working with "multiple disabilities" can be frustrating, it can be extremely rewarding to realize that chemical dependency is one preventable and treatable disabling condition. Moreover, traditional approaches to the treatment of chemical dependency can be applied (to both the client and the professional) as an aid in accepting the disabling conditions and learning to live productive lives.

Being mentally retarded doesn't mean that somone cannot learn. It just means that they learn at a slower rate. In fact, some report that clients "with developmental disabilities and substance abuse problems have seldom been able to maintain recovery without ongoing support" (Small, 1981). Social isolation and lack of social skills contribute to alcohol and substance abuse problems for those with developmental disabilities. It is important when providing services to such clients to help them identify and positively fulfill the need that drinking once did.

Listed below are a number of procedures that not only reflect the needs of individuals with developmental disabilities, but can assist professionals in developing realistic recovery expectations of the individual with a developmental disability who is in need of substance abuse services.

Procedures for Developing Programs

1. Extend length of treatment to promote understanding
2. Use supportive techniques
3. Use direct approaches
4. Emphasize education about alcohol
5. Repeat concepts
6. Implement short-term, concrete goals
7. Use behavioral contracts with positive reinforcers
8. Treat clients with more patience
9. Teach positive use of leisure time
10. Coordinate services with all service providers and family/guardians

High-Risk Factors

When working directly with individuals who have developmental disabilities and need substance abuse services, it is important to understand some basic differences between prevention and treatment. The goals of prevention are 1) to identify high-risk individuals--those who have not yet, but are most likely to, experience problems with substance abuse and, 2) through education and other prevention strategies, prevent or delay the onset of abuse. Treatment, on the other hand, is for those in need of intervention and recovery from already harmful substance abuse and/or dependency.

The differences between prevention and treatment have numerous implications. For example, prevention efforts, with the main emphasis on education, may be conducted by a variety of

trained professionals, whereas treatment should only be conducted by certified substance abuse counselors or other specially trained therapists. Prevention issues will also differ from treatment issues. For example, relapse (a return to chemical abuse) is a main topic in treatment but is not a high priority for prevention efforts. Likewise, common issues will have different emphases, with different goals in mind. For example, the prevention goal of teaching "resistance to negative peer pressure" is to delay or prevent the onset of substance use, whereas the goal of teaching resistance techniques to those in treatment is to prevent relapse and maintain abstinence.

The following section presents a widely accepted philosophy and approach to prevention and treatment which focuses on "high-risk factors." This information is not meant to train professionals to become experts in diagnosis. Rather, it is hoped that this overview will provide the reader an understanding of the impact that environmental, social and psychological factors can have on the involvement an individual has with chemicals. An understanding of these relationships can greatly enhance the ability to identify persons in need of services and, therefore, lead to earlier referrals and appropriate intervention.

The Individual and "High-Risk" Factors

One of the basic philosophies in prevention and treatment is that certain "high-risk" factors greatly determine a person's

inclination to use or abuse drugs in compensating for personal inabilities to deal successfully in these areas.

This "high-risk" concept has received wide-spread acceptance among prevention and behavior specialists. Two nationally known prevention programs--the Charlotte Drug Education Center in Charlotte, North Carolina and the Christian Civic Foundation in St. Louis, Missouri--and the Office of Substance Abuse Prevention (from which this material is adapted) subscribe to this concept.

There is no certain factor or set of factors to determine whether an individual will experience substance abuse problems. However,

> Knowing the common characteristics which are associated with developing substance abuse problems can be helpful in several ways. It can enable the clinician, the educator, the parent or the individual himself or herself to be alert to the possibility that a problem is more likely to develop. This can translate into better focused prevention efforts or more active early intervention strategies. (Peterson, 1988)

Since the "high-risk" concept assumes that lack of success in certain life areas tends to encourage drug abuse lifestyles, prevention and treatment programs should provide the means to foster accomplishment rather than failure in these areas. The following are some basic "high-risk" realms to consider in assessing individual needs as well as in designing prevention and treatment approaches.

Self-Esteem/Self-Awareness. How a person views, values, and accepts himself/herself is a vital life skill. Persons of low self-esteem and those whose self-awareness is clouded with uncertainty often use drugs to assuage their negative feelings

about themselves. Prevention/treatment should encourage the building of self-esteem and personal awareness.

Coping Skills. How persons deal with stress and situations threatening their sense of well-being can determine whether drug use becomes a means of coping. Learning to cope positively with feelings and stressful situations without drugs is a goal of effective prevention and treatment. For individuals with developmental disabilities, coping skills must be broadened to include issues surrounding the struggle to accept one's disability (Hazelden Professional Update, 1989).

Personal Valuing. The value system by which a person lives can sometimes be unclear and inconsistent. Too often the choice to use drugs results from electing to follow the values of another. When one develops a workable and personal valuing process of which he/she is proud, reliance on the values of others begins to fade. Knowing how to clarify, state, and act upon one's values is a prime objective of prevention/treatment.

Interpersonal Relationships. Related closely to "high-risk" areas is the matter of interpersonal relationships. People who have trouble relating to others often find drugs a means of escape. An inability to relate meaningfully to others can greatly affect one's sense of belonging and place, which can negatively affect an individual's choice-making in peer selection. Prevention and treatment should help a person develop abilities for relating meaningfully with others and with selecting positive peer relationships.

Authority. How a person views authority can well determine his/her social attitudes. If authority figures (such as parents, teachers, case managers or trainers, law officials, and the like) have been a chronic threat, the individual will disdain their demands, position, and power. Drug use has become a means of defying such authority. Prevention and treatment should lead a person into a positive relationship with and acceptance of authority by helping the person understand and overcome antagonism toward authority figures. Additionally, authority figures may need to learn new behaviors and attitudes regarding their interactions with those they supervise.

Boredom. Drug use often results when two factors occur at once: boredom and drug availability. Many individuals with developmental disabilities face the additional challenge of looking forward to an excess of leisure time filled with minimal resources. Add to that boredom their feelings of low self-concept and esteem, inability to cope, and poor communication skills, and the escape of a drug high seems very attractive indeed. Effective prevention and treatment will teach alternative responses to boredom and provide resources and accessibility (Gourguechon, 1986).

Alcoholism in the Family. Having an alcoholic parent doubles the risk of the child becoming alcoholic or a drug abuser. This is, at least in part, genetic. Studies have found that children of alcoholics, even when reared apart from their alcoholic parents, have higher rates of alcoholism than those

without this heritage. This occurs even when the foster parents are not alcoholic.

Family History of Criminality. This may be due to role-modeling socially deviant behavior. It is also possible that delinquent behavior has biological as well as social origins (Peterson, 1988).

Inconsistent Discipline. Excessively severe discipline accompanied by constant criticism may not only lower self-esteem but may also unwittingly encourage drug use as a means of self-medicating stress. Conversely, permissive behavior may fail to set appropriate limits or make any behavior, including drug abuse, appear to be acceptable. Parents/guardians who are permissive in their own attitudes and personal behavior regarding substance abuse encourage similar behavior in their children (Peterson, 1988).

Failure in School/Employment. Studies show that individuals who are unsuccessful in school or work are more likely to become substance abusers and are more likely to begin using substances at an earlier age than their more successful peers. An additional source that can create a sense of failure is exemplified by the disabled student in a public school system or the disabled employee in a community setting who grapples with isolation and rejection from fellow students or employees. An effective prevention/treatment approach will include the involvement of schools and employers.

Peers Who Use Substances. If one's friends, acquaintances or siblings use, the individual is far more likely to do so.

People are most often introduced to substance abuse by a peer wishing to share the excitement of the drug-using experience or who "deals" to support his or her own use. Effective prevention and treatment teach positive peer pressure and provide effective techniques to cope with negative peer pressure (Hazelden Professional Update, 1989).

Delinquent Behavior. Drug abuse has been correlated with disruptive classroom behavior, heightened childhood and adolescent aggression and other forms of predelinquent or delinquent behavior. Adolescents with precocious sexual experience are also of higher risk. A common thread to these behaviors is poor impulse gratification and intolerance of adult control. The possibility that some of these persons may have minimal brain damage, which may contribute to their low frustration tolerance and makes drug use especially reinforcing, must also be considered (Peterson, 1988).

Age of First Use. Those who began smoking in childhood are more likely to become heavy smokers, to drink early and to later abuse other drugs. Marijuana use prior to age 15 has been found to be associated with heavier use later, as well as with using other drugs. Thus, one of the major goals of prevention efforts is to delay the onset of use.

"Gateway" Drugs. The early use of tobacco, alcohol, and marijuana--the "gateway" drugs--sets a fairly typical progression in the use of licit and illicit psychoactive drugs. Use generally begins with alcohol or tobacco and progresses to marijuana before experimentation with sedatives, stimulants and

hallucinogens. Smoking and oral ingestion almost always precede intravenous drug use, although only a very small percentage of drug users ever become IV users. This progression is by no means invariant nor does it indicate that use of one drug "causes" the use of the next. It is uncommon, however, that for one who has not used marijuana to use more exotic drugs, such as LSD.

Gateway drugs may play a role in substance abuse in several ways. Their use may teach an early reliance on drugs to provide an easy "high," rather than striving to develop academic, social or athletic prowess that could provide a natural "high." For some, these natural highs may be less accessible due to their own limited mental or physical ability, or due to social/economic barriers that exclude the individual from participation. Early use may also be especially attractive for those for whom psychoactive drugs are highly reinforcing for biological reasons (Hawkins, Lishner, & Catalano, 1985).

Effective prevention and treatment measures have shown that when people learn their drug abuse often results from their inability to deal successfully in life skills, and a workable means of effecting positive change is given them, they begin to develop those skills instead of compensating for them with chemical highs. It is at that point substance abuse prevention and treatment have succeeded.

Once professionals understand the basis of "high-risk" factors and are sensitized to the nature of and potential for substance abuse problems, it is possible to identify and work

effectively with those individuals who can benefit from substance abuse services. Below is a questionnaire reprinted from The Maine Approach (1984), which is an excellent example of the type of screening device a program will want to make a standard part of their intake procedures. The information is gathered from concerned others, i.e., casemanagers, employers, trainers. Any item answered "yes" indicates a "red flag" or reason for further investigation. There are no absolute scores. Remember, it is not the purpose of this device to diagnose, only to spot whether further assessment is prudent. Programs may want to, with the assistance of a trained substance abuse counselor, establish a policy to decide what "score" or factors will result in a referral to a substance abuse professional for assessment.

Caseworker Questionnaire

Please fill out this questionnaire for your clients who drink alcohol or take drugs.

		YES	NO
1.	Do you worry about your client's drinking or chemical use?	___	___
2.	Do you spend more than the average amount of time managing client's case?	___	___
3.	Have you ever had to assist the client in locating new housing because of his or her drinking behavior? How many times in the past 2 years? ____	___	___
4.	Does your client function at a level which is lower than you expect he or she is capable of?	___	___
5.	Does your client have a history of poor memory retention? If not, has this recently become a problem for your client?	___	___
6.	Has your client experienced any kinds of problems while or shortly after he or she has been drinking or drugging?	___	___
7.	Does your client experience mood swings?	___	___
8.	Is your client defensive about his or her drinking or drugging?	___	___
	Does your client brag about his or her substance abuse?	___	___
9.	Do you try to control your client's drinking or drugging?	___	___
10.	Are other people (such as family members) concerned about your client's substance usage?	___	___
11.	Does your client have trouble getting along with others?	___	___
12.	Has your client ever been fired or refused work as a result of his or her drinking or behavior?	___	___
13.	Are you afraid of physical or verbal abuse when your client is drinking or using chemicals?	___	___

14. Does your client spend money that is budgeted for food, clothing, or household on alcohol or drugs? (If you are the client's representative payee, is he or she often coming to you for extra money)? ___ ___

15. Is client on prescribed medication? If so, does your client abuse or misuse these drugs? ___ ___

16. Does your client stop taking his or her medications when drinking? ___ ___

Once a referral is made to a substance abuse program, an assessment of the individual's needs may be required. Below is an example of the kinds of questions a substance abuse counselor will want to ask the referral source and other concerned parties in order to effectively coordinate services and work together as a team, as well as to verify responses given by the client.

Counselor's Assessment with Concerned Others

* What led up to the client coming here?

* Do you think you client has a problem with alcohol or other drugs?

* What are your expectations?

* What do you think the client's motivation and expectations for being here are?

* What do you see as the client's coping skills?

* What things are important to your client?

* Who does your client trust?

* How does your client deal with authority?

* Describe your client's living situation?

* Do you know of specific motivators for your client?

* What are your recommendations for this client?

* Are you willing to participate in the treatment process?

* * * * * * * * * * * * * * * * * * *

Assessment of Client

I. Assess Needs of Individuals

1. Maturity
2. Learning skills - can individual read/write/count?
3. Social adjustment: Street-wise or lives in supervised residence
4. Actual age

II. First Contacts

1. Minimize any threat
2. Encourage parental involvement, but set time alone with client to gather information about chemical use and personal history
3. Speak in simple terms
4. Ask individual what she/he understands about the program
5. Ask what they would like to do or get from such a program
6. Describe the possibilities of the program (set limits)
7. Offer praise to clients, and thank them for their honesty and willingness to talk with you
8. Find out what is needed to assist individuals so they can fully participate
9. Have written materials available for both agencies and families

Below is an example of the kinds of questions the substance abuse counselor will want to ask individuals with developmental disabilities who have been referred for services. This questionnaire was adapted from The Maine Approach (1984) and can be instrumental in determining appropriate services for clients.

Counselor Administered Questionnaire

NAME_____ DATE OF BIRTH_____

ADDRESS_____ PHONE_____

DATE_____ CASE MANAGER_____

OTHER CONCERNED PERSONS AT INTAKE_____

_____

Who referred you to our group? _____

What do you know about the group? _____

_____

What do you want to learn or do in this group?_____

_____

Have you received any education/information/counseling about chemical use before?_____

_____

Do you feel uncomfortable being here?_____

FAMILY

Guardian_____

Mother_____Father_____

Siblings_____

Has anyone in your family had a drinking/drug problem?_____

_____

Describe your current living situation and how long you have lived at this residence:_____

_____

How do you like your living situation?_____

_____

If you live with others, does anyone else there drink/use?_____

_____

Describe your relationship with your family:_____

_____

_____

OTHER CONCERNED PERSONS

List any other close friends of individual:_____

_____

_____

List services individual receives, including contact person:

_____

_____

_____

_____

EDUCATION/WORK HISTORY

Highest grade completed:_____

Read?_____Write?_____ Count?_____ At what level(s)?_____

_____

Do you work/attend school? (if so, where)_____

How long have you worked there?_____

What kind of work do you do?_____

What do you do best at work?_____

Do you like your job/school?_____

What's hard about your job/school?_____

Who manages your money?_____

Has there been any trouble at work/school because of your drinking or drug use? _____

LEISURE TIME

How do you spend your free time? (or when not doing a program)___

_____

_____

_____

What are your favorite activities?_____

_____

How often do you do these favorite activities?_____

_____

NEEDS/RESOURCES FOR GROUP

What days are best to meet for group?_____

What hours are best to meet?_____

What hours/days are you already busy?_____

_____

Do you use: City bus?_____Drive_____Other_____

Any hearing/vision/mobility problems?_____

_____

List needs:_____

_____

_____

MEDICAL HISTORY

1. Seizure disorder?_____
2. Allergies?_____
3. Medications?_____
4. Illnesses?_____
5. Physical problems?_____
6. Mental illnesses?_____
7. Date of last physical evaluation?_____
8. Date of last psychological evaluation?_____
9. Names of Doctors_____

CHEMICAL USE HISTORY

What are your present drinking/using habits? (frequency and amounts)_____

_____

When, and with whom did you first drink/use?_____

_____

What do you usually drink/use?_____

Where do you do most of your drinking/using?_____

_____

With whom do you do your drinking/using?_____

How have your drinking/using habits changed over time?

_____

How do you act when you drink/use?_____

_____

How does it make you feel?_____

_____

What kinds of problems or trouble has your drinking/using caused?

_____

_____

People drink for different reasons. How important would you say that each of the following is to you as a reason for drinking?

a. I drink because it helps me to relax

b. I drink to be sociable

c. I drink because people I know drink

d. I drink when I get angry

e. I drink when I want to forget everything

f. I drink to celebrate special occasions

g. I like the taste

h. A drink helps me forget my worries

i. A small drink improves my appetite

j. I accept a drink because it's the polite thing to do

k. A drink helps cheer me up when I'm in a bad mood

l. Drinking helps me feel better when I feel uptight

m. Drinking helps me make friends

Have any of the following ever happened to you while drinking?

a. I spent more money than planned

b. Friends used up more money than I wanted them to

c. I couldn't remember some of the time while drinking

d. I got into a fight with someone

e. I broke the rules at home

f. Friends/strangers hurt my feelings

g. Someone beat me up

h. Someone stole from me

i. Someone sexually assaulted me

j. I forgot promises I made to someone

k. I lost track of time

l. I got stranded without transportation

m. I did something I was ashamed of later

n. I got scared by something that happened while drinking

o. other: _____

The above assessment process is not meant as the "end all" in assessment procedures. It does, however, provide a place from which to start gathering important data that will assist in service planning for individuals. Furthermore, the Client Assessment should be used only as a guide. Remember to go at the pace of the client and reduce terminology to the individual's abilities. It can be helpful, for example, to clarify "Has this ever happened, even once?" or to state the item in two or three different ways to ensure understanding.

One last form of assessment is suggested as a manner in which to assess the effectiveness of the intervention strategy utilized. It is recommended that these questions be asked of the client in individual sessions before and after intervention. Such a questionnaire should contain items reflected by the topics presented during intervention. It will often be necessary to rephrase statements and to ask for feedback to ensure clear communication. This form of assessment will help identify what the client has learned and can provide insight for further program development.

NAME _____ DATE _____

Circle T if you think the statement is True. Circle F if you think the statement is False.

T F Alcohol is a drug

T F Alcohol can help you drive better

T F Alcoholism is a mental illness

T F Smoking marijuana (pot) can make you clumsy

T F Coffee can sober you up

T F Men can drink more than women

T F A good meal before drinking can help you control your drinking

T F Drinking alcohol does not affect the brain

T F TV commercials about alcohol can affect drinking habits

T F You can tell an alcoholic just by looking at them

T F Alcohol improves a person's ability to think clearly

T F A shot of whiskey makes you more drunk than a can of beer

T F Alcohol can be harmless and enjoyable

T F Alcohol is the only legal drug

T F Anyone who drinks can become an alcoholic

T F Mixing alcohol with medications is harmful

T F Alcohol is fattening

T F Alcohol can change your mood

T F Taking more medicine than the doctor orders is drug abuse

T F Marijuana (pot) is safer than alcohol

T F Gulping drinks is alcohol abuse

T F You can always predict the affects alcohol will have

T F Marijuana is abused more than any other drug

T F When you abuse alcohol, you only hurt yourself

T F An alcoholic is someone who drinks every day

T F A pregnant woman can drink safely

T F Alcoholism cannot be treated

T F Almost every adult drinks alcohol

T F Inhaling paint thinner or hair spray is a safe high

T F Too much alcohol can damage your body

T F Drinking to forget problems is drug abuse

T F Light beers have less alcohol than regular beers

T F It is legal to smoke marijuana in Montana

Using a Small Support Group Format

Listed below is an outline of eight sessions suggested for a substance abuse support group with individuals who have developmental disabilities. Within each session's description, examples of materials are provided. If and how these materials are used will depend on the makeup and goals of the group and may be modified for use in individual sessions. It is important to consider, for example, whether goals will be geared to prevention and education, or intervention and treatment. It is also important to consider the level of functioning of individuals in the group. A group member, for example, who functions at a lower level than the rest of the individuals can take more energy, yet the dynamics can be used to enhance group cohesiveness by encouraging other members to help and feel good about offering support.

The details of the suggested sessions rely heavily on materials used for the general population. Therefore, it will be important to keep the following techniques in mind as you develop your own materials or adapt others for persons with disabilities.

1. Whenever possible, use age-appropriate materials. If not appropriate, use developmentally-appropriate materials (chronological age may not be an accurate indicator of needs).
2. Speak clearly and slowly.
3. Use short sentences with an appropriate vocabulary.
4. Limit number of ideas and concepts.
5. Repeat concepts.
6. Use pictures, audiotapes, videotapes, film, etc. to capture interest and enhance understanding.

DD Support Group: Suggested Outline of Sessions

Session 1. ENGAGE GROUP: Use the first session to establish rapport and comfort, to clarify expectations, and to encourage personal involvement.

a. Ice-breaker Exercises

- Share your nickname, how you got it, and how you feel about it.
- Break into dyads, give 10 minutes for introductions and have each person introduce their new friend to the group.
- Have everyone tell about one of their favorite activities.

b. Group Rules

Developing group rules can provide structure and offer a sense of ownership to the members (Lindbo, 1986). Involve the members as much as possible in developing group rules. Once established, use the opening of each meeting to ask members to recall group rules and encourage members to remind one another of them when appropriate. Examples of possible group rules include:

- Everyone will be given the opportunity to share
- Use words that are not offensive to others
- Confidentiality: "What is said here, stays here"
- Be on time
- Refrain from interrupting when someone is speaking
- We are here to offer acceptance and support, not judgement
- Remove hats
- Everyone arrives "clean and sober"

Session 2. **ALCOHOL AND OTHER DRUGS:** An Introduction to Their Effects.

a. Looking at Alcohol and Other Drugs, Alex Boros, pp. 17-64.

b. Thinking about Drinking (film). Color, 17 minutes. Basic facts about various alcoholic beverages, effects on body, nervous system and behavior. 1981.

c. By using an outline of the human body, with major organs outlined, present information on the path alcohol takes through the body. Discuss the process by which alcohol is eliminated from the body and how long this process takes. Talk about the long-term effects of alcohol on the body. Following the presentation, hand out an outline of the human body and have group members draw the path of alcohol through the body (Lindbo, 1986).

Session 3. **ALTERNATIVES TO SUBSTANCE ABUSE:** Explore alternatives, values, coping skills, decision-making.

a. Looking at Alcohol and Other Drugs, pp. 193-203.

b. Looking at Treatment for Alcoholism, Alex Boros, "Having Fun Without Alcohol and Other Drugs," pp. 135-145, and "Making Decisions," pp. 145-155.

c. Almost Everyone Does (film). Color, 17 min. Good and bad feelings, and how to cope.

d. Drugs and Alcohol: Viable Alternatives (film). Color, 28 min. Deals with boredom and search for instant gratification. Through role-play and discussion, we

discover this to be a matter of values clarification and realistic goal-setting.

e. Alcohol and Drugs? Making the Decision (film). Color, 26 min. Exploring alternatives to alcohol and drug dependence. 1980.

Session 4. PEER PRESSURE: It is important to learn to apply different skills to overcome peer pressure. For persons with developmental disabilities, applying these skills can be particularly difficult. The need to fit in, low self-esteem, lack of decision-making skills and an undefined personal set of values will undermine efforts to change behavior. Unfortunately, these issues are often exaggerated for those with developmental disabilities, especially those who are higher functioning, know they are different, and have therefore felt rejection repeatedly.

a. Looking at Alcohol and Other Drugs, pp. 175-193.

b. Straight At Ya (videotape). Kurt Cameron shows techniques to say no to drug use. Comes with a teacher's guide for discussion.

c. Role Play: Ask members to demonstrate different ways to say no. Set up different scenarios in which they can respond. Provide praise and encouragement. Increase audience participation by having them come to the aid of their friend who is confronted with the temptation to use. Discuss positive vs. negative peer pressure, and how members can be supportive of one another's choice to not use.

Session 5. REVIEW: Repeat concepts from former sessions to promote learning.

a. Game Quiz

- Make up a number of questions from earlier discussions.
- Assign point value to multiple choice and open-ended questions.
- Break up into two teams, have them assign a spokesperson.
- Read question, stating its point value (5, 10 or 15 points).
- If first team has incorrect answer, pass to the second team.
- Encourage discussion and consensus before leader answers.
- Keep score on blackboard or newsprint.
- Always provide correct answer if not given, and encourage discussion to promote understanding.
- Set up a reinforcer for "winning team," e.g., winners choose first group recreation activity.

Session 6. PRESCRIPTION MEDICATION: Effects of Drug Interactions.

a. A Practical Guide to Independent Living, by Alice Phillips and Caryl K. Roman, pp. 61-65.

b. Things You Should Know about Prescription Drugs (free pamphlet). Dept. of Health and Human Services, U.S.

Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857.

Some individuals will be on medications for other physical or emotional problems. Concepts to cover include the following:

- What you should tell your doctor
- What you should ask your doctor
- Drugs and alcohol effects on medication
- How to take medications safely and effectively

Session 7. **ALCOHOLISM/CHEMICAL DEPENDENCY:** Signs and Symptoms. It can be difficult to convey the concepts of signs and symptoms of chemical dependency. Breaking them down into 1) a definition, 2) physical symptoms, 3) mental symptoms and 4) behavioral symptoms can be helpful. You may wish to devote several sessions to this subject.

a. Looking at Alcohol and Other Drugs. Chapters three through six discuss the following: 3) What Is Alcoholism, 4) Physical Symptoms of Alcoholism, 5) Mental Symptoms of Alcoholism, and 6) Behavioral Symptoms of Alcoholism.

b. Alcoholism (videotape). Color, 23 min. Recovering person points out the symptoms of alcoholism, the body's dependency on the drug, and the progression of the disease relating it to her personal experiences.

c. There Is Hope (videotape). Color, 28 min. Explains the progressive stages of the disease with sensitivity and understanding.

Session 8. **ALCOHOLISM AND THE FAMILY:** How alcoholism affects family members; what family members can, and cannot, do.

a. Looking at Alcohol and Other Drugs, pp. 145-163.

b. The Family Trap, Sharon Wegscheider, 1976. Persons with developmental disabilities are affected by family alcoholism, too. The Family Trap describes the family roles and how each person copes with having a chemically dependent person in the home. The illustrations in the book can be enlarged and used to help group members identify their major role and coping mechanisms. Not every group member will have come from an alcoholic home. To help each person identify and become more aware of themselves, point out that everyone takes on different roles in their family.

Activities

Providing alternatives to drinking is important for persons with developmental disabilities because they are reluctant to experiment without direction and guidance. It is also difficult for persons with developmental disabilities to make plans to get to activities or events. The added stress they feel can easily result in the choice not to go at all. Therefore, it is helpful to make planning a distinct part of the group process. Areas to consider in planning include:

- Transportation to and from activity
- Time needed to get there

- Amount of money needed, and where the money will come from
- Directions, if needed
- Appropriate clothing such as swim suits, tennis shoes, etc.

Involve members in choosing different activities, and encourage exposure to new forms of entertainment. In Project ADAPT, a guest speaker from an outdoor recreation program presented slides of different activities available. As a result, one individual enrolled in kayak lessons. Others expressed interest in camping, hiking, rafting and horseback riding.

Transportation and money can present major barriers to participating in different activities. Individuals with developmental disabilities often live on fixed income from Social Security Income or Social Security Disability, and some are employed. Many require assistance with money management.

Matters of money and participation in activities should be coordinated with guardians, parents, case managers, employers and direct service providers from the onset. Explain to them that offering activities provides alternatives which can reduce the risk of chemical involvement. Ask them what they can do to help. If they help manage the individual's money, perhaps they can plan a certain amount each week for group activities. Maybe they would provide transportation or offer needed reminders to plan on attending the meetings. Also, seek help from businesses. Local theatres, swimming pools, and parks are a few suggestions of places that may offer special discounts.

Don't forget interested volunteers. In Project ADAPT an Alcoholics Anonymous member provided transportation and used Alex Boros' book, Twelve Ideas for My Improvement, to assist a group member in understanding the concepts of Alcoholics Anonymous.

Individuals should be encouraged to participate in recreational activities outside the group and share their experiences with the rest of the members each week. In Project ADAPT this resulted in new friendships, and participation in recreational activities increased.

SUMMARY

Alcohol abuse is now the third leading disease, ranked only below heart disease and cancer. There are more than nine million persons with problems related to alcohol abuse in the United States but it is uncertain just how many persons with developmental disabilities are affected by alcohol problems. Alcohol abuse does not discriminate against persons of various socio-economic levels. It also appears that a person's intellectual level is not a factor in determining susceptibility to alcoholism.

Acceptance and opportunities to socialize are important to everyone. Information gathered suggests that, for persons with developmental disabilities who abuse alcohol, drinking facilitates acceptance and assists in socialization. For many people, drinking a moderate amount of alcohol contributes to temporary relief from frustration and problems. The difficulty is that when alcohol becomes a problem for the individual who has

a developmental disability, there are no existing resources that can meet the person's needs.

Available treatment programs need to adopt special treatment techniques to successfully treat the problems of the person with a developmental disability who has a drinking problem. Policy-makers and direct service providers in the professions of substance abuse and developmental disabilities must work together to modify and change approaches in order to better serve the individual with a developmental disability who has a substance abuse problem.

Review the Literature

By reviewing the literature, one becomes the expert on a subject. Knowledge about substance abuse among persons with developmental disabilities and what is currently being done lends credibility, helps avoid pitfalls, promotes skill development and prevents needless work re-inventing the wheel. Listed below are several primary sources used to implement Project ADAPT.

PRIMARY SOURCES

TRIC Library in Helena: The Training, Resources and Information Center (TRIC) is a special library of the Developmental Disabilities Division. Anyone may use their resources and, since TRIC is a lending library, materials are loaned free of charge. You can also receive bibliographies on subject areas of interest. TRIC provided a number of the materials used in this project. For more information, contact:

TRIC
25 South Ewing, Room 200
Helena, MT 59620
(406) 449-8326

AID Bulletin, Kent State University: AID (Addiction Intervention with the Disabled) is a quarterly newsletter. The cost is $6.75 for four issues. Make checks payable to "KSU, AID Bulletin." It is a good idea to order back issues. In addition to excellent information, some contain lists of current literature on the subject of substance abuse and disabilities.

Picture Book Ideas: Another of Dr. Boros' projects, the Picture Book Ideas, includes very relevant publications for education and treatment of persons with developmental disabilities. These materials were used extensively in Project ADAPT. They include:

1. Looking at Alcohol and Other Drugs ($37.00)
2. Looking at Treatment for Alcoholism ($37.00)
3. Twelve Ideas for My Improvement. Adapted 12-step program. Please specify Male or Female. ($7.67 for book and set of instructions.)
4. There is a new, hot-off-the-press curriculum for grades seven through twelve about Looking At Alcohol and Other Drugs ($30.00).

For further information, contact:

Alex Boros, AID
Department of Sociology
Kent State University
Kent, OH 44242
(216) 672-2440 (Voice/TDD)

Chemical Dependency Bureau, Department of Institutions, Helena, MT: Montana's Prevention Coordinator is knowledgeable about current resources and literature regarding the development of prevention and education programs and knows persons at the local levels who are involved in prevention, education and treatment. Also the Certification Coordinator can provide a list of all state-approved chemical dependency programs and certified counselors in Montana upon written request. For further information, call or write:

Marcia Armstrong, Prevention Coordinator
Chemical Dependency Bureau
Department of Institutions
1539 11th Avenue
Helena, MT 59620
(406) 444-2878

Alcohol Outreach, Fargo, North Dakota: Carol Lindbo has developed Alcohol Abuse and the Developmentally Disabled: A Guide for Professionals based on her experiences in developing and providing services for persons with developmental disabilities. The last printing of the guide sold for $25.00; it is accompanied by a videotape available for a minimal rental fee. Project ADAPT was modeled after this program, which emphasizes the importance of community involvement as well as adapting substance abuse services to meet the needs of persons with developmental disabilities. For further information, call or write:

Alcohol Outreach, Inc.
1325 South 11th Street
Fargo, ND 58108
(701) 293-7341

The Maine Approach: A Treatment Model for the Intellectually Limited Substance Abuser: Bureau of Mental Retardation, Maine Department of Mental Health and Mental Retardation (1984). The lack of communication between the substance abuse and disabilities professions is identified as a primary area to address in developing services for individuals with developmental disabilities. The model provides sample contracts and agreements between agencies, as well as areas for professional cross-training and methods to use in assessment and treatment of the substance abusing individual who has a developmental disability. It also contains examples of contracting with clients.

Bay Area Project on Disabilities and Chemical Dependency: Survey of professionals' involvement with and understanding of individuals who have disabilities and experience substance abuse problems. Contact:

Linda Cherry
Bay Area Project on Disabilities and Chemical Dependency
875 O'Neill Avenue
Belmont, CA 94002
(415) 595-0783 (Voice/TDD)

The Good Life: A Smart Choice: A booklet about alcohol and other drugs. A good educational resource for clients with developmental disabilities. Written at a primary grade reading level, eight pages, $1.00 each. A companion audiotape was also created with alcohol and drug education with three decision-making skits in which the listener must make choices about the

use of chemicals ($2.00). Requests for educational materials should be made to Linda Cherry at:

Bay Area Project on Disabilities and Chemical Dependency
1034 Clubhouse Drive
Hayward, CA 94541

California Alcohol, Drug and Disability Study: A research project to generate data and recommendations for improving accessibility to the California alcohol and drug service system. By surveying disability professionals and people with disabilities, the study provides valuable information about the recovery needs of a wide variety of people with disabilities, including developmental disabilities. Contact:

John de Miranda
California Alcohol, Drug and Disability Study
Coalition on Disability and Chemical Dependency
2165 Bunker Hill Drive
San Mateo, CA 94402
(415) 578-8047

The Seed: Published by the Coalition on Disability and Chemical Dependency. A quarterly newsletter with up-to-date information, resources, research and conferences concerning persons with disabilities and their recovery needs. Contact:

James Bouquin
Coalition on Disability and Chemical Dependency
P.O. Box 7044
San Mateo, CA 94403
(415) 723-1039 (Voice) or (415) 723-1067 (TDD)

Film Library: Montana Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. Call 444-5277 Monday-Friday, 12:30-4:30 p.m. All films and videos discussed

are available here. Request an order form and directions for use of the library.

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